Connecticut Department of Social Services

Making a Difference

Testimony Before the

Select Committee on Aging

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Good morning Senator Prague, Representative Serra and members of the Select Committee on Aging. My name is Claudette Beaulieu and I am the deputy commissioner for programs of the Department of Social Services. I am pleased to be here this morning to present testimony on a bill introduced at the request of Governor Rell implementing the State Department on Aging. My testimony includes written remarks on several other bills on the agenda.

S. B. No. 841 AN ACT CONCERNING THE STATE DEPARTMENT ON AGING

The department supports the Governor's Bill # 841 re-establishing a State Department on Aging (SDA). This bill provides for the transfer of functions, powers and duties of the Aging Services Division and the Long Term Care (LTC) Ombudsman program of the Department of Social Services to a new Department on Aging effective July 1, 2009. The bill transfers the following programs/ responsibilities from DSS to SDA:

- all Older Americans Act programs and Area Agencies on Aging to SDA
- the LTC Ombudsman program from DSS to SDA
- the CHOICES Program from DSS to SDA
- Adult Foster Care Program from DSS to SDA
- Alzheimer's Respite Program.

The department supports the Governor's bill because it provides for the development of a Department on Aging that is consistent with the spirit of the Older Americans Act. The Older Americans Act calls for each state to designate a State agency as the sole State agency to:

- Be primarily responsible for the planning, policy development, administration, coordination, priority setting, and evaluation of all the State activities related to the objectives of the Older Americans Act;
- Serve as an effective and visible advocate for all older individuals and their caregivers; and
- Provide assurances that preferences will be given to providing services to older adults with the greatest economic and social need.

The bill keeps intact certain core services at the Department of Social Services that serve all groups including older adults. The carving out of these services would be counter-productive and would increase costs to the state while not providing any added value to the constituents served.

S. B. No. 993 (RAISED) AN ACT CONCERNING THE FUNCTIONS, POWERS AND DUTIES OF THE DEPARTMENT ON AGING

SB 993 would provide for the transfer of functions, powers and duties of the Aging Services Division, Alternate Care Unit and the State Ombudsman of the Department of Social Services, to a new Department on Aging effective July 1, 2009.The department opposes this bill because it moves functions to the Department on Aging that are more appropriate for DSS.

Legislating the transplantation of extremely complicated yet successful direct-service programs from DSS into the new agency, as S.B. No. 993 proposes, could be a prescription for confusion and disorganization over the coming years. There are also programmatic, oversight and legal obstacles.

With respect to the Connecticut Home Care Program for Elders, federal law requires eligibility determination be made by staff in the Medicaid agency. DSS cannot delegate Medicaid eligibility responsibilities to any other entity.

Regarding the state-funded portion of the Home Care program, eligibility determination is made by the same DSS eligibility staff using the same eligibility system. DSS also has an intricate information system for purposes of obtaining federal revenue for Medicaid programs through an approved federal claiming process.

With regard to the clients receiving services, it begs the question whether elders and their families would now have to deal with two agencies – Aging and DSS (the Medicaid agency). The notion of pulling Medicaid programs or state-funded programs such as the Connecticut Home Care Program for Elders away from the agency that is required to establish the financial eligibility process jeopardizes the goal of enhanced customer service, creates a bifurcated eligibility process and is counterproductive to the goal of a single point of entry

More generally, the State of Connecticut is striving to enhance current long-term care services and develop new options for elders and adults with disabilities in its continuing drive to 'rebalance' the system and support more clients in remaining at home in the least restrictive environment. This process is a challenging one, requiring a comprehensive approach to changing the long-term care system in Connecticut as part of a national initiative to enhance quality of life and mitigate Medicaid costs. The Connecticut Home Care Program for Elders is the cornerstone of our rebalancing efforts.

First and foremost, the home care program is a major component of a full continuum of long-term care paid by Medicaid. It is intrinsically linked to the Money Follows the Person demonstration, as well as a transition for non-elders who are aging out of other programs, including other Medicaid waivers. It is also linked to the pre-admission screening and the medical necessity payment process for Medicaid payments to nursing homes.

Since the program has both a state-funded and Medicaid component, the objective has been to provide a seamless transition for clients from one eligibility group to another without interrupting services. The program is incorporated into DSS systems, including eligibility management and the Medicaid Management Information system. Under federal law, the Medicaid agency must retain the determination of waiver eligibility, both functional and financial. Replicating systems in another agency would be cost-prohibitive and would likely not be as seamless to the clients as the current system in place. Nationally, the trend is to link aging and disability services to provide a comprehensive long-term care system of care. Separating programs in different agencies would be contrary to that trend.

DSS was able to implement a new pilot program for persons under 65 without adding any new staff or resources by incorporating it into the existing home care program infrastructure. If the program were in another state agency, such efficiencies would not have been possible.

Considering all the efforts the state and department is initiating to serve all populations in a seamless manner, as has been undertaken in the Money Follows the Person Program and the Nursing Home Diversion program, this separation of responsibilities would be counter-productive. Under these programs, both citizens with disabilities and those of advanced aged are served by determining eligibility and providing functional assessments in a seamless process without creating silos based on disability or age. This is consistent with what has been expected from both federal Centers for Medicare and Medicaid Services and Administration on Aging.

S.B. No. 993 also seems to ignore the sheer challenges involved in moving federal/state medical assistance programs and state social work programs and underestimates the value of a unified eligibility system and federal claiming system.

In addition, the Department of Social Services has the infrastructure and the control mechanisms to run a program this size. There are quality of care, quality assurance, audit, and fraud detection and prevention efforts that would have to be duplicated in a Department on Aging in a transfer of the level proposed in S.B. No. 993.

The department does not favor a bill that would uproot direct-service Medicaid and social work programs from an environment where they work for people, tap economies of scale, and offer a community presence through 12 DSS field offices, and coordinate with similar programs.

For all these reasons, the department opposes S.B. No. 993.

The scope and mission for a Department on Aging as envisioned in Governor Rell's bill #841 presents, by comparison, a workable and cost-effective approach to re-establishing a stand-alone agency for Connecticut's older adults.

S. B. No. 488 (COMM) AN ACT CONCERNING THE METHOD OF STATE REIMBURSEMENT TO NURSING HOMES

This bill requires the department to implement a prospective case-mix payment system for nursing facility services by January 1, 2011. It also permits the department to develop plans for case-mix payments for residential care home (RCH) and Intermediate Care Facility/Mentally Retarded (ICF/MR) services. In SFY 2008, the department expended approximately $1.3 billion for nursing facility services (Avg. Rate $215/day), $42.0 million for RCH services (Avg. $86/day) and $60.1 million (Avg. $460/day) for ICF/MRs.

Currently, the department uses cost-based prospective methods to set rates for nursing facilities, RCHs and ICF/MRs. The methods do not directly account for differences in resident care needs. Case-mix and resource-based/treatment specific payment systems used by Medicare and other state Medicaid programs (34 states) link payment rates to resident care requirements (i.e. estimated nursing, aide and therapy hours and other care related variable costs). Adoption of such systems will likely result in Medicaid payment increases for some facilities and reductions to others.

The bill requires the submission of a case-mix payment plan for nursing facilities to committees of cognizance by January 1, 2010 and implementation effective January 1, 2011 for new admissions and all residents after January 1, 2012. It should be pointed out that the federal regulations (42 CFR 440.200) governing the Medicaid program would prohibit the department from phasing-in case-mix payments by date of admission.

Development of a case-mix payment system for nursing facilities will require additional resources for consulting services to examine various case-mix methods including benefits/negatives of systems as well as analyze and estimate administrative and Medicaid program costs/savings. It is estimated that the department would require approximately $400,000 to obtain these necessary services.

We are not opposed to studying and planning for a new payment method, including other payment alternatives, for nursing facilities; however, we recommend: 1) moving the legislative report date from December 31, 2009 to March 1, 2010 to allow adequate time for engaging outside expertise and thorough analysis of various methods; and 2) removing the new payment system implementing dates from the bill since administrative and Medicaid program costs/savings should be fully considered by the Administration and the General Assembly before establishing a start date in statute.

H. B. No. 5678 (COMM) AN ACT PROVIDING FINANCIAL ASSISTANCE TO GRANDPARENT CAREGIVERS

This bill would increase the payment standard for child only assistance units in the Temporary Family Assistance (TFA) program to the foster care rate paid by the

Department of Children and Families. It is assumed that the intent of this bill is to only provide the increase to those headed by a non-parent caretaker relative, as the term "caretaker relative" is not defined. Parents are caretaker relatives of their own children as the term is commonly used in the TFA program.

The department must oppose the bill because of the significant costs associated with providing such a benefit increase. The DCF foster care rate ranges from $745 to $823 per child, depending on the child's age. In the TFA program the normal flat grant payment standards are provided for these children, $354 for one child and $470 for two children in such families. There are approximately 5,900 children cared for by about 4,600 non-parent caretaker relatives in the TFA program. Increasing the benefit levels as the bill proposes would result in additional annualized costs of over $25 million.

H. B. No. 6540 (RAISED) AN ACT CONCERNING PRESCRIPTION EYE DROP REFILLS

DSS currently maintains a prior authorization process for the dispensing of early refills of prescription drugs dispensed in a retail pharmacy setting. The changes proposed under the bill seem to fall under the criteria of an early refill. The department's prior authorization process requires that a prior authorization be acted on within 2 hours. Prior authorization for early refills are initiated by a pharmacist and are acted on immediately (other than for controlled drugs which need physician intervention). If a medical necessity, this request would be approved and the client would most likely walk out of the pharmacy with their needed medication.

Given that the department has a proven prior authorization process in place, we must oppose this legislation.